

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG-TERM CARE AND HEALTH RETIREMENT ISSUES COMMITTEE
PHILADELPHIA, PENNSYLVANIA
JULY 13, 2013
MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care and Health Retirement Issues Committee met at the Philadelphia Marriott Downtown in Philadelphia, Pennsylvania, on Saturday, July 13, 2013, at 11:30 a.m.

Rep. Susan Westrom of Kentucky, Vice Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Kurt Olson, AK	Sen. Jerry Klein, ND
Rep. Greg Wren, AL	Rep. Don Flanders, NH
Sen. Jason Rapert, AR	Sen. Neil Breslin, NY
Rep. Ron Crimm, KY	Rep. Brian Kennedy, RI
Rep. Tommy Thompson, KY	Rep. Charles Curtiss, TN
Rep. Greg Cromer, LA	Rep. Bill Botzow, VT
Sen. Dan Morrish, LA	Sen. Mike Hall, WV
Rep. George Keiser, ND	

Other legislators present were:

Rep. Romy Cachola, HI	Rep. Michael Stinziano, OH
Rep. Angus McKelvey, HI	Rep. Nick Kotic, PA
Rep. Jeffrey Roy, MA	Rep. Marguerite Quinn, PA
Sen. David Robinson, MI	Sen. Roger Picard, RI
Sen. Tom Facey, MT	Rep. Steve McManus, TN
Assem. Kevin Cahill, NY	Sen. Deidre Henderson, UT

Also in attendance were:

Susan Nolan, Nolan Associates, NCOIL Executive Director
Candace Thorson, Nolan Associates, NCOIL Deputy Executive Director
Jennifer Webb, Nolan Associates, NCOIL Director of Legislative Affairs–DC
Eric Ewing, Nolan Associates, NCOIL Director of Legislative Affairs

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its March 8, 2013, meeting in Washington, D.C.

LONG-TERM CARE

Jane Sung of the National Association of Insurance Commissioners (NAIC) reported that rate increases on older long-term care insurance (LTCI) policies remain the top issue for the NAIC Senior Issues Task Force. She said that these policies were underpriced when originally issued and regulators are now seeing requests for large rate increases. She stated that the task force is developing a model bulletin, which they hope to complete by the end of the year. She said that the bulletin is intended to serve as a common framework for cooperation between state regulators and insurance companies as they address proposed rate increases. She said that the bulletin, while not a complete solution, is an attempt to address the concerns of states, insurers, and consumers.

Ms. Sung said that rate increases on newer, rate-stabilized policies covered under previously adopted NAIC regulatory changes have prompted regulators to revisit NAIC standards, originally adopted in 2000. She said the standards were designed to encourage accurate upfront rating and discourage subsequent rate increases. She said that NAIC will soon circulate a draft of proposed amendments to these standards.

Eileen Tell of Univita, a care management company, stated that no one financing option addresses all long-term care needs. She said that there are drawbacks among the available options such as qualifying criteria, limited coverage, and high costs to consumers. She said that programs like Medicare and Medigap are often mistaken for long-term care coverage. She said that the modern LTCI market offers more comprehensive coverage than in the past, fewer barriers to benefits, and better access to care. She said that an important development for LTCI is that those who wish to remain in their homes now have more flexibility because payment for nursing home care and home care have reached similar levels. She said that premium increases on LTCI have largely been a result of improvements in coverage, though she suspected that in recent years “right pricing” has played a role in making the product more expensive.

Ms. Tell said that overall LTCI sales have slowed down for a number of reasons. She said that cost was the most commonly cited reason among those that considered LTCI but ultimately decided not to buy. She said, however, that customers generally overstate the cost of buying LTCI and understate the risk of not having coverage. She said that the economic recession has been the primary cause of weak sales due to subsequent rate increases, declines in personal income, and a persistent low-interest rate environment.

Addressing market exits, Ms. Tell stated that common reasons given for exiting the market include low profitability, limited access to capital, and declining interest in the product due to new management or poor risk evaluations. She said that rate increases and product design modifications are typical changes companies make in order to stay in the market. She suggested that going forward the industry should consider improvements such as cost-sharing, increasing consumer awareness about the product, and methods used in public sector models.

In response to a question from Sen. Rapert, Ms. Tell said that neither companies nor states are actively promoting the long-term care partnership program, often due to a lack of funding on the state side. She said that there is some evidence that people buy policies because of the partnership program, but there is also evidence that it is not a significant factor in the market because some consumers are buying partnership-backed policies without even knowing.

2014 MARKET REFORM IMPLEMENTATION

Dianne Bricker of America’s Health Insurance Plans (AHIP) stated that provisions of the Affordable Care Act (ACA) effective in 2014 will result in new costs. She said that the provisions include guaranteed issuance for those with pre-existing conditions. She said that while this change will bring peace of mind and security to many consumers, it will also increase medical spending, the costs of which will be spread among all insured. She said that average claim costs in state-administered high-risk pools are eight and a half times higher than those in the individual market. She said that this reform is largely the reason for the individual mandate, as states that have required coverage for pre-existing conditions without establishing universal coverage have experienced large premium rate increases.

Ms. Bricker stated that more comprehensive coverage is mandated by essential health benefits requirements, the cost of which will be built into premiums. She stated that premiums will no longer be based on health status or medical history, and there will be strict limits on factoring in age and tobacco use. She said this will likely result in premium increases for younger, healthier consumers and a drop in rates for older consumers. She stated that approximately sixty percent of consumers will be eligible for premium tax credits.

Ms. Bricker said that the ACA imposes new taxes and fees, including a federal tax on policies that insurance companies sell to individuals, families, small and mid-size employers, Medicare Advantage beneficiaries, and state Medicaid programs. She said that there are also new taxes on pharmaceuticals, medical devices, and fees associated with funding reinsurance. She stated that the Congressional Budget Office (CBO) projects that these new costs will largely be passed on to consumers in the form of higher premiums. She stated that in the final analysis, many consumers will see significant changes in 2014, but some who are currently insured will also see higher costs.

Ms. Sung said that the NAIC Regulatory Framework Task Force will soon complete work on a model regulation for the individual and small-group markets. She said that the NAIC is taking a broad look at all of its models to ensure that they are in line with ACA regulations.

Ms. Sung stated that the Consumer Information Subgroup is developing a set of frequently asked questions to assist state insurance department staff with consumer outreach. She anticipated that starting this summer there would be a surge in consumer questions regarding ACA market reforms.

Ms. Sung then outlined a number of areas that NAIC committees and working groups will study in the coming months, including potential issues related to self-insurance using stop-loss coverage; monitoring and enforcement of the ACA, specifically relating to state responsibilities such as market conduct exams and complaint tracking procedures; navigator, producer, and assister oversight; and anti-fraud issues.

MEDICAID EXPANSION

Dr. Mark Duggan of the University of Pennsylvania reported that Medicaid now represents the largest component of state spending. He said that the program insures forty percent of all children and up to two-thirds of nursing home residents. He said that the Medicaid provisions of the ACA expand coverage to those earning less than 138 percent of the federal poverty line. He said that the federal government will fully cover expansion costs for the first three years before trending down to 90 percent of costs in 2020. He said about a third of the total number of persons eligible for Medicaid coverage under the ACA live in states that intend to expand, while almost half are in states that are not expanding.

Dr. Duggan said that Medicaid expansion will eliminate the need for some uncompensated care costs. He stated that this may keep costs down for consumers, as hospitals and other healthcare providers would otherwise raise prices due to uncompensated care costs. He said that if the federal government continues to match Medicaid funds at ninety percent most states will come out ahead financially.

Dr. Duggan said that some employers in states that do not expand Medicaid may face higher penalties as a result. He said that those employers that do not offer minimum essential coverage would be affected. He said that if such an employer has workers that are eligible for coverage through the exchanges and would otherwise be eligible for Medicaid if the state

expanded, employers could face penalties of up to \$3,000 per person for those not covered by Medicaid. He said that this would not affect the vast majority of employers.

Dr. Duggan stated that certain ACA provisions are financing Medicaid expansion by reducing costs in other areas. He noted, for example, reductions in disproportionate share spending—money to safety net hospitals that provide a disproportionate level of care to the uninsured and poor—due to fewer numbers of uninsured. He also noted that there will be reductions in Medicare reimbursement. He said that Medicaid expansion is intended to act as a cushion for many healthcare providers affected by these cuts. He said that states that do not expand may find their healthcare providers at a disadvantage, as the cuts will not be offset by additional Medicaid funds. He said that for eligible patients, Medicaid expansion offers lower medical costs and potentially greater access to care.

Dr. Duggan acknowledged that many states are skeptical that the federal government will continue to match Medicaid funds for newly eligible recipients at ninety percent in the future. He noted that it is a much higher rate than currently exists for Medicaid recipients in any state. He said that there have been proposals to consolidate match rates for different Medicaid populations into one state specific rate. He noted that Medicaid reimbursement is already lower than private insurance reimbursement in virtually all cases. He said that the question is if Medicaid reimbursement will decline further after expansion and if that will result in less providers willing to participate in the program.

Dr. Duggan reported that the Center for Medicaid & Medicare Services (CMS) projects that expanding Medicaid in every state would increase total program spending by about 95 percent to \$960 billion over the next eight years, a greater increase than projected spending on Medicare or private insurance over the same period. He said that under universal expansion the number of Americans on Medicaid could grow from one-in-six now to one-in-four by 2017. He said that it is important for states to learn from each other as they seek best practices for reducing costs.

MENTAL HEALTH PARITY MODEL FOR SUNSET/RE-ADOPTION

Due to time constraints, the Committee moved to defer a bylaws-required review of the *Mental Healthy Parity Model Act* to the Annual Meeting.

ADJOURNMENT

There being no other business, the Committee adjourned at 12:30 p.m.